the emergency, complete and comprehensive follow-up ultrasound studies can be appropriately done by radiology department personnel.

Radiologists perform admirably in comprehensive ultrasonography. Likewise, cardiologists, obstetricians, and trauma surgeons effectively use limited ultrasonography for specific purposes. Joining this group are emergency and other primary care physicians who can effectively use this valuable technology in a specific, limited, and immediate manner.

Courses in emergency ultrasonography are not intended to substitute for a radiology residency. They do, however, provide emergency or primary care physicians valuable information about a patient that on-call ultrasonography cannot. If ultrasonography is to be the stethoscope of the 21st century, we must allow equity in its use.

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Silicone Implants in Men

TO THE EDITOR: Teuber and colleagues in the May 1995 issue of THE WESTERN JOURNAL OF MEDICINE[1] address a problem that has been extensively studied and reported in the medical press, the national lay press, and other media. The extensive silicone gel implantation in men, however, which also began in the early 1960s, has all but been ignored. There exist as many as 400,000 testicular silicone implants, with initial implantations done more than 30 years ago. Would it not behoove the investigators to include men in their future investigations of silicone and their outcome-oriented studies?

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Congenital Malaria in Twins

TO THE EDITOR: Balatbat and colleagues, in their interesting report (in the May issue of the journal) of malaria in a young twin,[1] suggest that congenital malaria may remain "relatively rare" because of underreporting. Certainly, it is difficult to diagnose, and thus report, "classic" congenital malaria in endemic areas. As described by the authors, a classic presentation of congenital malaria includes fever, anemia, and splenomegaly during the second month of life. For children with such presentations in malaria-endemic areas of the world, it would not be possible to differentiate cases of congenital malaria from those acquired from mosquitoes. The diagnosis and reporting of such cases are thus limited to areas of the world where malaria does not usually occur.

The authors refer to the "rarity of congenital transmission" of malaria.[1] Actual transplacental transmission of *Plasmodium* is not uncommon, however. Reports show that as many as 29% of newborns in tropical Africa may be born with malaria.[2] Many of these children remain asymptomatic, but neonatal malarial infection has been associated with fever and death.[3]

Indeed, the question of malaria in newborn twins has not been well studied. This report prompted us to review recent data from an ongoing study of congenital malaria in Zaire. There were five pairs of twins among 337 births. Each mother of twins took prophylactic chloroquine and was smear-negative at delivery. Overall, 14 (4.2%) newborns had cord blood smears positive for malaria. One (10%) of the twins, the first twin born to a woman in whom fever developed and who had a positive malaria smear on the second postpartum day, had a positive smear. Multiple gestation was not significantly associated with the presence or absence of congenital malaria ($\chi^2 = .88$; $P = .35$). Pending larger studies, these initial data confirm that the congenital transmission of malaria to twins may be discordant and suggest that the frequency of prenatal transmission of malaria to twins is not substantially different from that to singletons.

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Drs Balatbat, Jordan, and Halsted Respond

TO THE EDITOR: We are grateful that Drs Fischer, Nyirjesy, and Toko have shared their larger experience on congenital malaria. Certainly in malaria-endemic areas of the world, it would be much more difficult to differentiate congenital malaria from mosquito transmission following delivery. Mosquito transmission of malaria in California has been documented occasionally. This was not known to have occurred in the Yuba City area at the time that our patient was seen. A large group of immigrants from Punjab, India, inhabit a farm community in the Yuba City area. With the travel of these persons and their families to and from India and the occasional relapse of malaria after long periods, this disease is not infrequently seen at the Sacramento Medical Center in both adults and children.

It is of interest that the congenital transmission of malaria to twins is discordant, as was the case with our patient. Data on malaria transmission to monozygotic twins are even more limited.

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Sarcoidosis and Beryllium Exposure

TO THE EDITOR: In the June 1995 issue of the journal, both Chesnutt[1] and Sharma[2] allude to the elusive nature of sarcoid disease and its diagnosis—the search for an etiologic agent, the factors instigating fibrosis, and recognizing the system-specific changes reflected in the presentation of a patient with sarcoidosis. I was surprised to find that neither diagnostician commented even briefly on the need to exclude beryllium exposure (occupational or environmental) in a patient's differential diagnosis. In Harrison's classic *Principles of Internal Medicine*, the need for a detailed clinical history is summed up as follows[3(p1071)]:

> Histologically, it may be difficult to differentiate the chronic form of [beryllium] disease from sarcoidosis. Unless one inquires specifically about occupational exposures to beryllium in the manufacture of alloys, ceramics, high technology ceramics, and before the 1950s in the production of fluorescent lights, one may miss entirely the etiologic relationship to an occupational exposure.

The need for an occupational history before characterizing "nonspecific lesions" as sarcoidosis has been further amplified.[4] The pulmonary presentation of nonspecific lesions—epithelioid granulomas with or without minimal necrosis or cytoplasmic inclusions—are characteristic of many other conditions besides sarcoidosis.[5]

My sole purpose for this correspondence is to remind those in primary care and internal medicine specialties about the fact that patients spend between a third and half of their working lifetime in a possibly complex-chemical job environment. The need to inquire, What do you do in your job, and what materials do you handle? cannot be ignored in establishing a differential diagnosis for sarcoid disease.

Once a history reveals a potential for unique or exotic exposures, clinicians should take the time to check their own library sources, ask the local university biomedical library to run a search, or seek counsel from an occupational medicine associate. If the medical evaluator fails to ask the questions that go beyond, "What is your occupation?" the potential may never be realized, and another elusive diagnosis may be lost.

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Dr Chesnutt Responds

TO THE EDITOR: I appreciate Dr Cohen's emphasis of the importance of a thorough occupational history in the diagnostic evaluation of granulomatous lung disease. As I mentioned in my article, "a careful history and physical examination, including an occupational history," is crucial in the diagnostic evaluation of a patient with suspected sarcoidosis. Such an evaluation is important because the clinical features of berylliosis are similar to those of sarcoidosis and include dyspnea, cough, weight loss, and fatigue. Chest radiographs of patients with chronic beryllium lung disease also usually show nodular or irregular opacities; hilar adenopathy is seen in 40% of cases.

In addition, as Dr Cohen astutely points out, chronic beryllium lung disease is histologically identical to sarcoidosis. In contrast to sarcoidosis, however, additional analysis of bronchoalveolar lavage fluid and lung tissue specimens can be done in patients with suspected berylliosis to help clarify the diagnosis. Proliferative responses of lung T cells to beryllium and chemical analysis of lung tissue for beryllium may yield useful information in patients with berylliosis. Once the diagnosis of beryllium lung disease is documented, however, therapeutic options are as limited as they are in sarcoidosis; corticosteroids are currently the mainstay of therapy for both disorders.[1] In addition, patients with beryllium lung disease should be counseled to ensure that they are no longer exposed to beryllium.

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